United States Department of Labor
Employees' Compensation Appeals Board

F.B., Appellant	)	
and	)	**Docket No. 18-0903**
	)	**Issued: December 7, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Charlotte, NC, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 27, 2018 appellant filed a timely appeal from a February 7, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has established greater than five percent permanent impairment of his right upper extremity for which he previously received schedule award compensation.

FACTUAL HISTORY

On February 11, 2015 appellant, then a 66-year-old city mail carrier, filed an occupational disease claim (Form CA-2) alleging that he sustained rotator cuff arthropathy as a result of carrying

[1] 5 U.S.C. § 8101 *et seq.*

a mailbag over his shoulder while in the performance of duty. He first realized that his condition was caused or aggravated by his federal employment on April 16, 2008. Appellant was last exposed to the conditions alleged to have caused his condition on February 11, 2015.

By decision dated September 2, 2015, OWCP accepted appellant's claim for right rotator cuff tear.

OWCP subsequently authorized right arthroscopic rotator cuff repair, arthroscopic subacromial decompression and bursectomy, and arthroscopic biceps tenodesis. The surgery was performed on October 19, 2015 by Dr. Jonathan J. Paul, an attending Board-certified orthopedic surgeon. OWCP paid appellant disability compensation on the periodic rolls beginning October 17, 2015.

On August 31, 2016 appellant accepted the employing establishment's offer for a full-time, modified assignment as a district webcam watcher and returned to work the same day.[2]

OWCP received an October 3, 2016 form report from Dr. Paul who found that appellant had 15 percent permanent impairment of the right upper extremity under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] Dr. Paul completed a Figure 15-2 worksheet, page 388, of the A.M.A., *Guides*. He noted that appellant's diagnosis was a massive rotator cuff tear of the right shoulder. Dr. Paul determined that appellant had class 1 impairment of his shoulder. He assigned a grade modifier 2 for functional history and physical examination. Dr. Paul applied the net adjustment formula of the A.M.A., *Guides*[4] and calculated a net adjustment of 2, which equated to grade E, 15 percent permanent impairment of the right shoulder.

By development letter dated November 3, 2016, OWCP advised appellant of the deficiencies in his schedule award claim and afforded him 30 days to submit additional medical evidence in support of his claim, including an impairment rating, which applied the standards of the sixth edition of the A.M.A., *Guides.*

In an undated letter, Dr. Paul advised that he used Figure 15-2 of the sixth edition of the A.M.A., *Guides* to arrive at his 15 percent right upper extremity impairment rating and submitted a duplicate copy of his October 3, 2016 impairment evaluation report. He believed that appellant had a good result from surgery. Dr. Paul advised that, although it was difficult to assess whether the rotator cuff tear, which tended to be long-standing, chronic and to develop over time, it was certainly caused by some wear and tear while working at the employing establishment for over 40

[2] By decision dated August 2, 2017, OWCP found that appellant's actual earnings as a district webcam watcher fairly and reasonably represented his wage-earning capacity and reduced his wage-loss compensation benefits to zero as his actual earnings met or exceeded the current wages of his date-of-injury position.

[3] A.M.A., *Guides* (6th ed. 2009).

[4] *Id.* at 411.

years. He concluded that appellant had reached maximum medical improvement (MMI) on May 31, 2016.[5]

OWCP referred appellant's case to Dr. Jovito Estaris, a Board-certified occupational medicine physician serving as an OWCP district medical adviser (DMA). It asked Dr. Estaris to review the case record, including Dr. Paul's October 3, 2016 report, and provide an opinion on appellant's permanent impairment under the standards of the sixth edition of the A.M.A., *Guides*.

In a February 15, 2017 report, Dr. Estaris noted that he reviewed a statement of accepted facts (SOAF) and medical records dated November 20, 2015 to October 3, 2016. He also reviewed Dr. Paul's October 3, 2016 report, and disagreed with his impairment rating. Dr. Estaris explained that Dr. Paul's impairment rating was deficient and did not follow the recommendations of the sixth edition of the A.M.A., *Guides*. He pointed out that Dr. Paul applied the incorrect criteria as he did not use Table 15-5, page 403, under which the highest rating for a rotator cuff full thickness tear was 7 percent and not 15 percent. In addition, Figure 15-2 was not the diagnosed-based impairment (DBI) grid for a rotator cuff tear. Dr. Estaris maintained that Dr. Paul failed to provide an explanation as to how his grade 2 modifiers for functional history and physical examination were assigned.

On March 5, 2017 appellant filed a claim for a schedule award (Form CA-7).

By letter dated December 1, 2017, OWCP referred appellant, together with a SOAF, the medical record, and a list of questions to Dr. Seth L. Jaffe, a Board-certified orthopedic surgeon, for a second opinion evaluation to determine whether he had ratable permanent impairment pursuant to the sixth edition of the A.M.A., *Guides* due to appellant's accepted right shoulder condition.

Dr. Jaffe, in a December 19, 2017 report, discussed appellant's history of injury and medical treatment. On physical examination he reported essentially normal findings with the exception of diminished range of motion (ROM) of the right shoulder based on his loss of ROM measurements. Dr. Jaffe noted that ROM was equal to a contralateral uninjured shoulder. He assessed appellant with a history of repair of the right rotator cuff. Dr. Jaffe advised that appellant had reached MMI on May 31, 2016, the date impairment rating was given by Dr. Paul. He related that the diagnoses upon which his impairment was based included history of rotator cuff tear, superior labral tear from anterior to posterior, acromioclavicular arthritis, and the surgery performed on October 19, 2014 to treat these conditions.

In an attached permanent impairment worksheet for the upper extremity dated December 19, 2017, Dr. Jaffe noted his diagnosis of right shoulder rotator cuff tear. He utilized Table 15-5 and found that appellant had class 1 impairment for loss of ROM. Dr. Jaffe assigned a grade modifier 1 for functional history (GMFH), a grade modifier 0 for physical examination (GMPE), and grade modifier clinical studies (GMCS). He determined that appellant had a grade C impairment, which yielded six percent right upper extremity permanent impairment.

[5] In a prior report dated May 31, 2016, Dr. Paul examined appellant, assessed him as being status post massive cuff repair, and released him from his care with a permanent lifting restriction.

In a separate sheet entitled, "Supplemental Range of Motion Examination Findings" dated December 19, 2017, Dr. Jaffe provided the results of three supplemental ROM measurements for various joints of appellant's right and left shoulders, which differed from his previous right shoulder ROM measurements.

On January 22, 2018 OWCP again referred appellant's case to Dr. Estaris to review the case record, including Dr. Jaffe's December 19, 2017 report, and provide an opinion on appellant's permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.

In a report dated January 28, 2018, Dr. Estaris advised that he had reviewed the medical evidence of record, including Dr. Jaffe's December 19, 2017 report, and disagreed with his impairment rating. He noted that the DBI method for rating impairment was applicable to appellant's diagnosis of right shoulder, complete rotator cuff rupture. Dr. Estaris found that appellant had five percent right upper extremity permanent impairment under the A.M.A., *Guides*. Utilizing Table 15-5, Shoulder Regional Grid, page 403, of the sixth edition of the A.M.A., *Guides*, he determined that appellant had a class 1 impairment with a default value of 5 for his right shoulder, complete rotator cuff rupture diagnosis. Dr. Estaris assigned a grade modifier 1 for GMFH due to pain on increased activity, modified work under Table 15-7, page 406. He assigned a grade modifier 1 for GMPE due to mild tenderness of the right shoulder and mild limitation of ROM under Table 15-8, page 408. Dr. Estaris noted that a grade modifier for GMCS was not used as no clinical study was included in the record for his review. He applied the net adjustment formula to reach zero, a class 1, default grade C for five percent permanent impairment of the right upper extremity. Dr. Estaris indicated that the difference between his impairment rating and Dr. Jaffe's impairment rating was that he used the DBI method while Dr. Jaffe used the ROM method. He noted that, while the ROM method was applicable to appellant's accepted injury, he could not use it to assess his permanent impairment. Dr. Estaris maintained that the ROM measurements provided by Dr. Jaffe showed inconsistent data. There was a marked difference between Dr. Jaffe's initial ROM measurements and the three supplemental ROM measurements for various joints of the right and left shoulders. Further, Dr. Estaris' calculation of impairment was not very specific as he did not indicate the impairment rating for the ROM measurement for each shoulder joint. He maintained that these measurements were inconsistent and, thus, unreliable and invalid. Dr. Estaris further maintained that Dr. Jaffe's statement that ROM was equal to the contralateral uninjured shoulder referred to the normal shoulder and, thus, it was presumed that there was no impairment to the left or right shoulder according to page 464 of the A.M.A., *Guides*. He concluded that appellant had reached MMI on May 31, 2016, the date noted by Dr. Paul and Dr. Jaffe.

By decision dated February 7, 2018, OWCP granted appellant a schedule award for five percent permanent impairment of his right upper extremity. The award ran for the period September 3 to December 21, 2016, for a total of 15.6 weeks of compensation, and was based on Dr. Estaris' January 28, 2018 opinion.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing federal regulations[7] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions, and organs of the body. FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[8] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[9] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides*.[10] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[11]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[12] The sixth edition requires identifying the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14]

The A.M.A., *Guides* also provide that the ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[15] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[16] Adjustments for GMFH may be made if the evaluator determines that the

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Ausbon N. Johnson,* 50 ECAB 304, 311 (1999).

[9] *Id.*

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (March 2017).

[11] *Isidoro Rivera,* 12 ECAB 348 (1961).

[12] *Supra* note 3, page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[13] *Id.* at 411.

[14] *Id.*

[15] *Id.* at 461.

[16] *Id.* at 473.

resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[17]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology based versus the ROM methodology for rating of upper extremity impairments.[18] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
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> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify: (1) the methodology used by the rating physician (*i.e.*, DBI or ROM), and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original.)[19]
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> The Bulletin further advises:
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> "If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.[20]
>
> "If the original impairment rating found by the DMA to be insufficient was provided from a second opinion or referee physician (*versus* the claimant's physician), the CE should request a supplemental/clarification report from the second opinion or referee physician to address the medical evidence necessary to complete the impairment assessment. Medical evidence received in response to this request should then be routed back to the DMA for a final determination. The

[17] *Id.* at 474.

[18] FECA Bulletin No. 17-06. This bulletin was effective for all decisions issued by OWCP on and after May 8, 2017.

[19] *Id.*

[20] *Id.*

CE should not render a decision on the schedule award impairment rating until the necessary medical evidence has been obtained."[21]

ANALYSIS

The Board finds that this case is not in posture for decision.

OWCP accepted appellant's claim for right rotator cuff tear. It authorized right arthroscopic rotator cuff repair, arthroscopic subacromial decompression and bursectomy, and arthroscopic biceps tenodesis performed on October 19, 2015 by appellant's physician, Dr. Paul. Appellant claimed a schedule award on March 5, 2017. By decision dated February 7, 2018, OWCP granted him a schedule award for five percent permanent impairment of the right upper extremity based on the medical opinion of its DMA.

Dr. Paul completed a Figure 15-2 impairment worksheet on October 3, 2016 and determined that appellant had 15 percent right upper extremity permanent impairment due to the accepted right rotator cuff tear. He found that appellant had a class 1 impairment of his right shoulder. Dr. Paul assigned a grade modifier 2 for GMFH and GMPE. He applied the net adjustment formula of the A.M.A., *Guides* and calculated a net adjustment of 2, which equated to grade E, 15 percent permanent impairment of the right upper extremity. However, Dr. Paul did not sufficiently explain how he calculated his assessment.[22] He did not identify any applicable tables and/or figures under the sixth edition of the A.M.A., *Guides* and he otherwise failed to explain how he arrived at his finding of 15 percent impairment.[23] Thus, the Board finds that Dr. Paul's report is of diminished probative value as it did not conform to the A.M.A., *Guides*.[24]

To ascertain the appropriate percentage of permanent impairment of appellant's right upper extremity, OWCP obtained a December 19, 2017 second opinion from Dr. Jaffe, a Board-certified orthopedic surgeon.[25] Dr. Jaffe determined that appellant had six percent permanent impairment of the right shoulder utilizing the ROM methodology for rating upper extremity permanent impairment. Dr. Estaris, OWCP's DMA, utilized the DBI method for rating upper extremity impairment and determined that appellant had five percent right upper extremity permanent impairment for a full-thickness rotator cuff tear under Table 15-5, Shoulder Regional Grid, page 403 of the A.M.A., *Guides*. The Board notes that Table 15-5 does allow, by asterisk, that a rotator cuff injury, full-thickness tear, be alternatively evaluated using ROM impairment.[26]

[21] *Id.*

[22] *Supra* note 3 at 28 (provides that a discussion of how the A.M.A., *Guides* criteria were applied to the medical information that generated the specific rating is required for an impairment evaluation to be consistent with the A.M.A., *Guides*); *see also A.S.*, Docket No. 10-1903 (issued May 20, 2011).

[23] *See C.H.*, Docket No. 15-0109 (issued April 16, 2015).

[24] *Id.*; *A.S.*, *supra* note 22.

[25] *D.H.*, Docket No. 18-0024 (issued May 7, 2018).

[26] *See supra* note 3 at 403, Table 15-5.

Because Dr. Jaffe provided a rating based upon appellant's loss of ROM which was allowed (for a diagnosed condition followed by an asterisk) under Table 15-5 of the A.M.A., *Guides*, Dr. Estaris should have independently calculated appellant's impairment using both the ROM and DBI method and identified the higher rating for the CE.[27] Dr. Estaris acknowledged that the ROM method was applicable to appellant's injury, but maintained that it was not possible to evaluate appellant's permanent impairment utilizing this methodology based on the deficiencies of Dr. Jaffe's ROM measurements used to determine his right upper extremity impairment rating. However, as he found that the medical evidence of record was insufficient to render a rating on ROM, he should have advised OWCP as to the medical evidence necessary to complete the rating.[28]

This case will therefore be remanded for further development consistent with the procedures outlined in FECA Bulletin No. 17-06. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision on the extent of impairment to appellant's right upper extremity.[29]

CONCLUSION

The Board finds that this case is not in posture for decision.

[27] *Supra* note 18.

[28] *D.K.*, Docket No. 18-0135 (issued August 20, 2018); *K.S.*, Docket No. 17-1922 (issued July 12, 2018).

[29] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the February 7, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision of the Board.

Issued: December 7, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board